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BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: MA FE CORPUZ DELEON AMIGABLE a.k.a. MA FE CARIDAD DAYOAN CORPUZ 717 Janice Lane Walnut, CA 91789 Registered Nurse License No. 223753 Respondent.	Case No. 2008-271 **A C C U S A T I O N**

Complainant alleges:

PARTIES

1. Complainant Ruth Ann Terry, M.P.H., R.N. brings this accusation solely in her official capacity as the Executive Officer of the Board of Registered Nursing, Department of Consumer Affairs, State of California (Board).

2. On or about May 31, 1972, the Board of Registered Nursing issued Registered Nurse License Number 223753 to Ma Fe Corpuz DeLeon Amigable a.k.a. Ma Fe Caridad Dayoan Corpuz (Respondent). The Registered Nurse License was in full force and effect at all times relevant to the charges brought herein and will expire on May 31, 2008, unless renewed.

JURISDICTION

3. This accusation is brought before the Board under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

STATUTORY PROVISIONS

4. Section 2750 of the Business and Professions Code (Code) provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

5. Code section 2764 provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license. Under Code section 2811, subdivision (b), the Board may renew an expired license at any time within eight years after the expiration.

6. Code section 2761 provides, in pertinent part:

"The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:

"(a) Unprofessional conduct, which includes, but is not limited to, the following:

"(1) Incompetence, or gross negligence in carrying out usual certified or licensed nursing functions.

". . . .

"(d) Violating or attempting to violate, directly or indirectly, or assisting in or abetting the violating of, or conspiring to violate any provision or term of this chapter [the Nursing Practice Act] or regulations adopted pursuant to it."

7. California Code of Regulations, title 16, section 1442, states:

"As used in Section 2761 of the code, 'gross negligence' includes an extreme departure from the standard of care which, under similar circumstances, would have ordinarily been exercised by a competent registered nurse. Such an extreme departure means the repeated

failure to provide nursing care as required or failure to provide care or to exercise ordinary precaution in a single situation which the nurse knew, or should have known, could have jeopardized the client's health or life."

8. California Code of Regulations, title 16, section 1444, states:

"A conviction or act shall be considered to be substantially related to the qualifications, functions or duties of a registered nurse if to a substantial degree it evidences the present or potential unfitness of a registered nurse to practice in a manner consistent with the public health, safety, or welfare. Such convictions or acts shall include but not be limited to the following:

"(a) Assaultive or abusive conduct including, but not limited to, those violations listed in subdivision (d) of Penal Code Section 11160.

"(b) Failure to comply with any mandatory reporting requirements.

"(c) Theft, dishonesty, fraud, or deceit.

"(d) Any conviction or act subject to an order of registration pursuant to Section 290 of the Penal Code."

9. California Code of Regulations, title 16, section 1443, states:

"As used in Section 2761 of the code, 'incompetence' means the lack of possession of or the failure to exercise that degree of learning, skill, care and experience ordinarily possessed and exercised by a competent registered nurse as described in Section 1443.5."

10. California Code of Regulations, title 16, section 1443.5 states:

"A registered nurse shall be considered to be competent when he/she consistently demonstrates the ability to transfer scientific knowledge from social, biological and physical sciences in applying the nursing process, as follows:

"(1) Formulates a nursing diagnosis through observation of the client's physical condition and behavior, and through interpretation of information obtained from the client and others, including the health team.

"(2) Formulates a care plan, in collaboration with the client, which ensures that

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direct and indirect nursing care services provide for the client's safety, comfort, hygiene, and protection, and for disease prevention and restorative measures.

"(3) Performs skills essential to the kind of nursing action to be taken, explains the health treatment to the client and family and teaches the client and family how to care for the client's health needs.

"(4) Delegates tasks to subordinates based on the legal scopes of practice of the subordinates and on the preparation and capability needed in the tasks to be delegated, and effectively supervises nursing care being given by subordinates.

"(5) Evaluates the effectiveness of the care plan through observation of the client's physical condition and behavior, signs and symptoms of illness, and reactions to treatment and through communication with the client and health team members, and modifies the plan as needed.

"(6) Acts as the client's advocate, as circumstances require, by initiating action to improve health care or to change decisions or activities which are against the interests or wishes of the client, and by giving the client the opportunity to make informed decisions about health care before it is provided."

11. Code section 118, subdivision (b), provides that the suspension, expiration, surrender or cancellation of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary action during the period within which the license may be renewed, restored, reissued or reinstated.

12. Code section 125.3 provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

FACTUAL ALLEGATIONS

13. From on or about January, 2002, through October, 2003, Respondent worked full time as a field nurse for Wescove. Her starting pay rate was $45.00 per home visit. Respondent explained that the intake coordinator at Wescove accepted referrals from physicians,

completed the intake forms, and would contact an available field nurse to assess the patient. As a field nurse, Respondent visited patients at their residences to perform assessments, check vital signs, monitor medications and instruct them on nutrition. After performing the initial assessment, field nurses returned to the office to input the information into a computer. The Home Health Care Certification and Plan of Care (Form 485) was generated from the computer information and sent to the physician for review and signature. Respondent stated that home assessments were routinely performed within 24 hours of the patient's hospital discharge. She further stated that approximately 30% of her job assignment was as the nursing supervisor overseeing the nursing care the Licensed Vocational Nurses (LVN's) provided at the patients' homes.

14. On or about January 5, 2004, the Board received a complaint from the Department of Health Services that a recertification survey they conducted at Wescove Home Health Services (Wescove) located at 306 North Lark Ellen in Covina, California, revealed that Respondent, while working as a field nurse for Wescove, had performed incomplete patient assessments and recruited patients at retirement centers for home health services.

Patient No. 23(Maria C.)[1]

15. The intake form indicates Respondent was the field nurse assigned to complete the initial assessment. Respondent completed the initial nursing assessment form for Patient No. 23 indicating she assessed the patient on September 28, 2003. The assessment is inaccurate. It indicates that the patient is able to walk only with assistance and is on complete bedrest, but during the DHS home visit on October 14, 2003, the patient was observed to be alert and ambulatory. The vital signs recorded indicate that the patient's heartbeat is regular with no indication of why the patient was being admitted to home health care. Respondent reported on the assessment form that she discussed the patient's medications with her including the purpose, dosage schedule, side effects and refills. However, Respondent failed to note that the following medications the patients had were expired: Vioxx expired March 7, 2003; Dical expired

1. Patients are identified by number to protect their privacy.

September 2003; Synthroid expired October 2, 2002; Lipitor expired June 21, 2002; and Nifedipine expired June 21, 2002.

16. Respondent transported the patient to Dr. Lei Ding, who reportedly ordered the home health care. The patient stated her regular physician is Dr. Hussein. The Home Health Care Certification and Plan of Care (Form 485) is not dated or signed by Dr. Ding. The physician order was purportedly signed by Dr. Ding on October 7, 2003.

17. Respondent documented one, one hour home visit with the patient on October 2, 2003. Her notes regarding the visit do not summarize any treatment given over a particular period of time or the patient's response to the treatment. The report indicates respondent instructed the patient regarding the purpose and dosage of her prescribed medications, including Lipitor, which had expired in 2002.

Patient No. 25 (Lena B.)

18. The intake form shows that Respondent was assigned to complete the initial assessment of Patient No. 25. Respondent recorded information on the initial nursing assessment form for this patient that home care started on September 16, 2003. Both the patient and Respondent signed the assessment form on September 16, 2003. The assessment form indicates that the patient is 5'8" tall and weighs 138 pounds. The form does not indicate that the patient smokes. The assessment form does not indicate that Respondent gave the patient any safety instruction about smoking.

19. Respondent documented home visits performed on September 19, 2003, September 22, 2003, and September 24, 2003. The documentation fails to note the care provided to the patient during a specific period of time and the patient's response to the care provided during a specific period of time. No other visits for the certification period September 16, 2003, through November 14, 2003, are documented in the patient records. The Home Health Certification and Plan of Care form (Form 485) for the period September 16, 2003, through November 14, 2003, is not signed by the physician or by the Respondent.

20. During a home visit on October 15, 2003, the DHS surveyors found that the medications on the plan of care were not consistent with what the patient was taking at home.

The patient takes Famotidine 40 mg twice daily, but the plan of care indicates Famotidine 40 mg once daily. When interviewed about the inconsistency, Respondent stated that the dosage had changed.

21. During the home visit on October 15, 2003, DHS surveyors observed that the patient was obese and that her home smelled like cigarette smoke. The patient advised the surveyors that she placed her oxygen tanks in the closet whenever she smoked. The patient also advised the DHS surveyors that she was always home and had a caregiver.

22. During the October 15, 2003 home visit the surveyors determined that the patient has in-home support staff (IHSS) – a sister who lives with her. The initial assessment form documents that respondent has a friend who is her care giver. The initial assessment does not document why home health services from Wescove were necessary.

Patient No. 27 (Ester C.)

23. The intake form indicates Respondent was assigned to complete the initial assessment of Patient No. 27. Patient No. 27 was not reassessed for the need for home health care services. Patient No. 27 and Patient No. 23 are sisters who live in the same household and have a caregiver who is very knowledgeable about the patients' medications and care. Respondent transported both patients to Dr. Lei Ding, who purportedly ordered the home health care services for the two patients, even though both patients indicated their physician is Dr. Hussein.

24. The original of the Home Health Certification and Plan of Care form (Form 485) for the period September 29, 2003, to November 27, 2003, is not signed by a registered nurse, but is purportedly signed by Dr. Lei Ding on October 7, 2003. The phone number listed on the form as belonging to Dr. Ding is incorrect. A copy of the Form 485 in the patient records is not signed by Dr. Ding but is signed by a registered nurse (not respondent) and dated September 29, 2003.

25. Although the "Start of Care" date on the Form 485 was September 29, 2003, Respondent purportedly completed the initial assessment of the patient on September 26, 2003. The initial assessment is incomplete.

26. Respondent documented two home visits after she completed her initial patient assessment: the first on October 2, 2003; the second on October 6, 2003. Respondent reported that she was at the home for one hour for each visit, instructed the patient regarding pain management on each visit, and instructed the patient on her low purine diet on each visit. However, respondent failed to document the location and level of pain. In addition, the documentation fails to note the care provided to the patient during a specific period of time and the patient's response to the care provided during a specific period of time.

27. During the home visit on October 14, 2003, the DHS surveyors noted that at least two of the patient's medications had expired before September 26, 2003, when respondent completed the home visit: Prednisone had expired on September 6, 2003 and Vioxx had expired on September 23, 2003. When interviewed, respondent stated she did not know that the medications provided to the survey team were expired. In addition, the survey team found that the nurse had not explained to the patient what a "purine" diet was, and Patient No. 27 did not know what it was.

28. During the home visit on October 14, 2003, the DHS surveyors noted that the patient was bald and was receiving chemotherapy. They also noted that the patient had hospice care.

29. During the home visit on October 14, 2003, the patient's care giver advised the survey team that respondent had spent only 15 minutes with the patient for the initial assessment.

FIRST CAUSE FOR DISCIPLINE

(Unprofessional Conduct: Gross Negligence towards Patient No. 23)

30. Respondent is subject to disciplinary action under Code section 2761, subdivision (a), and title 16, California Code of Regulations section 1442, in that she failed to accurately assess the patient initially; to instruct the patient about nutrition, medications and safety; to verify all medications with the physicians who ordered them; and to note that a number of the patient's prescriptions for drugs included in the plan of care had expired. The circumstances described in paragraphs 13 through 17 above are re-alleged and incorporated herein by reference as though fully set forth.

SECOND CAUSE FOR DISCIPLINE

(Unprofessional Conduct: Gross Negligence towards Patient No. 25)

31. Respondent is subject to disciplinary action under Code section 2761, subdivision (a), and title 16, California Code of Regulations section 1442, in that she failed to assess the patient accurately during the initial home visit, failed to instruct the patient about medications and safety, and failed to document follow-up visits with the patient. The circumstances are described in paragraphs 13 through14 and 18 through 22 above and incorporated herein by reference as though fully set forth.

THIRD CAUSE FOR DISCIPLINE

(Unprofessional Conduct: Gross Negligence towards Patient No. 27)

32. Respondent is subject to disciplinary action under Code section 2761, subdivision (a), and title 16, California Code of Regulations section 1442, in that she failed to accurately assess the patient initially; to instruct the patient about nutrition, medications and safety; to verify all medications with the physicians who ordered them; and to note that a number of the patient's prescriptions for drugs included in the plan of care had expired. The circumstances described in paragraphs 13 through 14 and 21 through 29 above are re-alleged and incorporated herein by reference as though fully set forth.

FOURTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct: Patient No. 23)

33. Respondent is subject to disciplinary action under Code section 2761, subdivisions (a) and (d), in that she recruited patients from Board and Care homes and transported them to physicians' offices. Wescove had orders for home health care for those patients reportedly from the physicians' offices where respondent had transported them. The circumstances described in paragraphs 13 through 14 and 16 above are re-alleged and incorporated herein by reference as though fully set forth.

FIFTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct: Patient No. 27)

34. Respondent is subject to disciplinary action under Code section 2761,

subdivisions (a) and (d), in that she recruited patients from Board and Care homes and transported them to physicians' offices. Wescove had orders for home health care for those patients reportedly from the physicians' offices where respondent had transported them. The circumstances described in paragraph 13 through 14 and 23 through 24 above are re-alleged and incorporated herein by reference as though fully set forth.

PRAYER

WHEREFORE, complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License No. 223753;

2. Ordering Respondent to pay the Board the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3; and

3. Taking such other and further action as deemed necessary and proper.

DATED: 3/24/08

RUTH ANN TERRY, M.P.H., R.N.
Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California

Complainant

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